Gerald M. Prill
Circuit Judge

STATE OF MICHIGAN

Ann M. Schultz
Friend of the Court

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52ND CIRCUIT COURT
FAMILY DIVISION
OFFICE OF THE FRIEND OF THE COURT

250 E. Huron Ave.,
Suite 211
Bad Axe, MI 48413

Uninsured medical expenses are governed MCL 552.511a as well as §3.04 of the Michigan Child Support Manual.

The enclosed forms must be used when requesting reimbursement of these expenses. In order for the Friend of the Court office to assist in collection of uninsured medical expenses, each step on the form must be followed. These steps are outlined under "*INSTRUCTIONS FOR REQUESTING PARTY*". Failure to complete each step will result in the forms being returned to you unprocessed.

The attached instructions apply to the special process for orthodontia expenses only. In the event you are requesting reimbursement for other types of uninsured healthcare expenses, please see the instructions under ***Uninsured Medical/Health Care Expense Reimbursement Process***.

UNINSURED MEDICAL/HEALTH CARE EXPENSE REIMBURSEMENT PROCESS

Instructions to Requesting Party

SPECIAL PROCESS RE: ORTHODONTIA EXPENSES

A major typically non-emergency expense for children is orthodontia. If you and your co-parent have ***joint legal custody***, the decision to proceed with treatment and incur this expense must be made together. It is a major financial commitment. If you proceed with such treatment without first securing the agreement of your co-parent or an order from the court, you will likely be denied reimbursement.

Parents having sole legal custody do not need co-parent consent. Please contact the Friend of the Court office for further instructions.

BEFORE PROCEEDING WITH TREATMENT, you must attempt to contact your co-parent and secure his/her agreement to proceed. You should notify your co-parent of all of the following:

- Name and contact information of the provider;
- The total cost of treatment and monthly payment plan amount;
- Whether any insurance coverage is available and its extent;
- Letter or report from the provider describing the treatment and why the treatment is necessary.

You are strongly encouraged to use the form ***Request for Health Care Expense – Othodontia***. By using the form, the communication information is preserved, including how and when you provided the information to your co-parent.

IF PARENTS AGREE ON TREATMENT, many will simply establish individual payment plans directly with the provider or with each other. FOC does not need to be involved. If parents agree on treatment and would like the reimbursement arrangements through the Friend of the Court office, you must submit the signed ***Request for Health Care Expense – Othodontia*** and proof of payment and/or a copy of the signed contract with the provider in the event payments will be made over time.

IF YOUR CO-PARENT DOES NOT AGREE TO THE TREATMENT OR IF YOUR CO-PARENT DOES NOT RESPOND TO YOU, you will need further assistance from Friend of the Court before proceeding with treatment. You will need to provide Friend of the Court with a copy of the ***Request for Health Care Expense – Othodontia*** together with all attachments to show you have attempted to communicate with your co-parent regarding this expense and treatment. Friend of the Court will likely schedule a court hearing so the court can determine whether the treatment should occur and each parent's responsibility for the treatment.

Original and attachments to Co-Parent;
Copy with attachments for your records; and
Copy with attachments for FOC

STATE OF MICHIGAN 52ND CIRCUIT COURT ☒ HURON COUNTY ☐ ☐	REQUEST FOR HEALTH CARE EXPENSE ORTHODONTIA ONLY	CASE NO.

Friend of the Court Address
250 E HURON AVENUE, SUITE 211, BAD AXE, MI 48413

Telephone Number
(231)922-4660

Plaintiff's name, address, telephone no.	V	Defendant's name, address, and telephone no.
TO: Name of person from whom reimbursement is sought:		

*NOTICE – YOU MUST ATTACH A COPY OF THE TREATMENT PLAN, A LETTER OR REPORT REGARDING THE NECESSITY FOR TREATMENT, ANY PROPOSED CONTRACTS AND A FULL ESTIMATE OF COSTS

Name of Child Receiving Service	Name of Medical Provider	Anticipated Date of Service	Estimated Total Cost	Amt Covered by Insurance	Amt Paid by Me Out of Pocket (if any)	Amt of Monthly Payment

Plaintiff's percentage of uninsured medical:_____ Defendant's percentage of uninsured medical:_____

I declare that the above statements are true to the best of my information, knowledge and belief and that on this date I mailed to my co-parent a copy of this Request, together with all attachments at his or her last known address stated above.

_____ _____
Date Moving party's signature

TO THE PERSON FROM WHOM REIMBURSEMENT IS SOUGHT:

You have 28 days from the date this REQUEST was mailed to you to respond. You may agree to the treatment or you may disagree. FAILURE TO RESPOND MAY BE TREATED AS AN ACQUIESCENCE TO TREATMENT AND REIMBURSEMENT OF YOUR SHARE OF THE EXPENSE.

I HEREBY AGREE TO THE PROPOSED TREATMENT (PAYMENT ARRANGEMENTS MAY BE MADE WITH MY CO-PARENT; WITH THE PROVIDER, OR, THROUGH FOC)

_____
Signature of co-parent (return to moving party or FOC)

I DO NOT AGREE TO THE PROPOSED TREATMENT BECAUSE:

_____

_____
Signature of co-parent (return to moving party or FOC)